DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Fiscal Year 2001 Budget Request

Witness appearing before the
House Subcommittee on Labor-HHS-Education Appropriations

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Statement by

Nancy-Ann DeParle
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on

Fiscal Year 2001 President's Budget Request
for the Health Care Financing Administration

Mr. Chairman and Members of the Subcommittee:

I am honored to be here today to present the Health Care Financing Administration's (HCFA) fiscal year 2001 budget request. The past year has been an exciting and challenging one for HCFA, full of many accomplishments. I'd like to tell you today about some of those successes as well as some of the challenges that lie ahead. I anticipate another busy and fulfilling year and look forward to continuing to work with the Members of this Committee.

As you know, HCFA is responsible for overseeing the Nation's two largest health care programs: Medicare and Medicaid. For a third of a century, these two programs have met the basic health care needs of the most vulnerable segments of our population: elderly, disabled, and low-income Americans. HCFA is also responsible for the State Children's Health Insurance Program, the Clinical Laboratory Improvement Amendments, the Health Insurance Portability and Accountability Act, and oversight of Medigap insurance.

My goal as Administrator is to ensure that HCFA's programs are responsive to our beneficiaries, strong, and well-managed. Meeting the health care needs of more than 70 million beneficiaries is HCFA's primary mission. We have an obligation to purchase services that are appropriate, effective, and of high quality. This concept, which we call "beneficiary-centered purchasing," is

at the core of HCFA's current and future direction and is the driving principle in our day-to-day operations.

HCFA has made great progress in meeting its many challenges. We have:

- Completed Y2K system certifications on time;
- Received high scores in a customer satisfaction survey, conducted under the auspices of the National Partnership for Reinventing Government;
- Cut the Medicare claims payment error rate in half over the period FY 1996-FY 1998;
- Fully implemented 70 percent of the 335 BBA provisions affecting HCFA, with many more partially implemented;
- Successfully instituted several aggressive initiatives to improve State nursing home inspections and enforcement, and to crack down on problem providers;
- Implemented a new national coverage policy-making process;
- Received the first place Gold Award for the best government health care website—*www.medicare.gov*—in the *Healthcare World* awards competition;
- Published, as part of our FY 2001 budget request, HCFA's first Annual Performance Report under the Government Performance and Results Act statute.

While we have made significant progress, much work remains to be done. I have made the fight against fraud, waste, and abuse in Medicare and Medicaid my number one priority. Our goal is to pay claims correctly the first time around. This means paying the right amounts to providers for covered, reasonable and necessary services for eligible beneficiaries. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides us with a mandatory funding source for fighting fraud and abuse. And, in 1997, the Balanced Budget Act

included several new authorities to help us in this effort. Now, we can bar felons from ever participating in Medicare again, impose civil monetary penalties on providers who take kickbacks, reform the payment system for home health care, and obtain more information on providers so that we can check their history and judge their suitability. Our efforts are beginning to pay off. Over a two-year period, HCFA halved its payment error rate for Medicare fee-for-service payments, from 14 percent in FY 1996 to 7.1 percent in FY 1998. We are working to further reduce the error rate by continuing to focus our corrective actions on vulnerable areas identified by the OIG, with a goal of reducing the error rate to 5 percent by FY 2002. Much of our improvement can be attributed to HCFA's corrective action plan. HCFA also remains committed to achieving, and keeping, a "clean" opinion from the Office of Inspector General on the Chief Financial Officer's audit of HCFA's financial statement.

My second priority is oversight, including strengthening Federal oversight of nursing home quality and safety standards, and improving oversight of our Medicare contractors. The President's Nursing Home Initiative focuses attention and resources on ensuring that beneficiaries in nursing homes receive quality care in a safe environment. To this end, we will be working with States to improve their nursing home inspection systems, to crack down on those nursing homes that repeatedly violate safety rules, to publish nursing home quality ratings on the Internet, and to reduce the incidence of bed sores, dehydration, and malnutrition.

On another front, we have developed a comprehensive approach to improving performance among the private companies that, by law, process and pay Medicare claims. Our strategy includes: standardizing and strengthening contractor performance evaluation; building a business-like internal control structure at the contractors, focused on financial management and electronic data

processing (EDP) internal controls; creating a team of over 100 financial management experts at the contractors' sites to help ensure a consistent and coordinated response to suspected instances of fraud and waste; and developing an integrated, dual-entry accounting system that can ensure accurate reporting and recording of financial data. I believe that a uniform accounting system with general ledger capabilities will help HCFA. It will also standardize reporting and facilitate error detection, thus enhancing prevention of fraud and abuse.

Finally, we must continue to implement the many new provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act of 1997 (BBA), and, now, the Balanced Budget Refinement Act of 1999 (BBRA).

Both BBA and HIPAA require a concentrated and coordinated effort to manage resources effectively. We have made tremendous progress in these areas. With the exception of provisions delayed by Y2K and those becoming effective in future years, HCFA has either completed or is well on its way to implementing virtually all of the 335 BBA provisions. Our progress with the national Medicare education campaign includes a new toll-free Medicare+Choice telephone help line, informational materials on health plans in both English and Spanish, a nationwide community-based outreach campaign to help beneficiaries understand their options, and an award-winning web site—www.medicare.gov— which provides comparison and quality data on health plans. We have also made great strides in implementing the State Children's Health Insurance Program (SCHIP). All 56 States and territories now have approved SCHIP plans in operation. During FY 1999, nearly 2 million low-income, uninsured children were served. Much work remains. The BBRA of 1999 includes 133 provisions requiring HCFA implementation. We have

developed a schedule and a system to track our progress with this new workload.

One of the BBRA provisions, however, seriously jeopardizes our Medicare+Choice education campaign. The BBRA significantly reduces the Medicare+Choice user fee, from $95 million in FY 2000 to $19.3 million in FY 2001, based on a formula in statute. If HCFA is to meet the beneficiary information needs associated with the Medicare+Choice program, we must continue to receive sufficient funds. This budget includes a request for an additional $130.7 million in Medicare+Choice user fees, consistent with our prior proposal to permanently increase the annual authorization level for this user fee to $150 million. I respectfully ask for the Committee's support for this proposal.

In addition to the workload challenges presented by HIPAA, BBA and BBRA, HCFA also recognizes that 35 percent of its current workforce is eligible to retire within the next five years, taking with it valuable institutional knowledge. In an effort to meet workload expansions and to integrate new staff now, this request includes an additional 120 FTEs: 20 FTEs to implement the Nursing Home Initiative and 100 FTEs to improve Medicare contractor oversight. We are also developing and integrating a workforce planning process into our overall agency planning agenda.

In order to meet its many challenges, HCFA is developing an initiative to strengthen its management capacity. This initiative has five components: 1) enhance management flexibilities; 2) increase accountability to constituencies; 3) improve program flexibilities; 4) institute structural reforms; and 5) initiate contracting reform. Together, these reforms would give HCFA greater flexibilities in a wide variety of areas including: increasing its ability to hire the

right skill mix for its mission; creating an advisory committee with representatives from the private sector who have expertise relevant to HCFA's business function; entering into more competitive purchasing arrangements with providers; realigning the relationship between HCFA's regional and central offices to ensure greater consistency in oversight and enforcement; and expanding the pool of potential Medicare contractors. As HCFA continues to make progress on management reform initiatives, we will also begin to explore a more stable source of funding to help HCFA meet its challenges well into the future.

HCFA's FY 2001 budget request includes three accounts of interest to this Subcommittee: Grants to States for Medicaid; Payments to the Health Care Trust Funds; and HCFA Program Management. I will briefly highlight the first two accounts and then discuss HCFA's Program Management request in more detail since Program Management funds are key to accomplishing our priorities.

GRANTS TO STATES FOR MEDICAID

In FY 2001, the Medicaid program will serve almost 34 million eligible persons, not including beneficiaries covered by the State Children's Health Insurance Program. Federal Medicaid obligations for FY 2001 are estimated at more than $124 billion, an increase of about 7 percent, or $8 billion, over FY 2000. Combined Federal and State Medicaid expenditures are projected to reach $219 billion in FY 2001, of which the Federal share is about 57 percent. We are committed to continue working with the States to encourage efficiency in the Medicaid program, as well as innovative expansions of health care coverage, particularly through the State Children's Health Insurance Program.

PAYMENTS TO HEALTH CARE TRUST FUNDS

Our FY 2001 request of $70.4 billion includes a Federal general revenue contribution to the Supplemental Medical Insurance (SMI) Trust Fund of $69.8 billion, an increase of $4.7 billion over the expected FY 2000 Federal SMI contribution. The major factors driving the increase in the FY 2001 Federal contribution for SMI are: growth in program outlays due to medical service price inflation; increased utilization of medical services; and demographic growth in the beneficiary pool.

PROGRAM MANAGEMENT

Our FY 2001 Program Management request of $2.3 billion supports the President's commitment to a balanced Federal budget, even in the midst of implementing the most sweeping changes since the Medicare and Medicaid programs were begun over 30 years ago. Excluding Medicare Contractor funding, our FY 2000 appropriation exceeded our request by $8.7 million. We greatly appreciate the Committee's support. I believe that all of us would agree with the importance of maintaining a stable and adequate level of resources to ensure that HCFA's programs are strong and well-managed, and that they provide our beneficiaries with the best possible service.

To put our Program Management request in perspective, it is actually less than 1 percent of total program outlays. This compares very favorably to the Blue Cross and Blue Shield Association's advertised administrative funding rate of 12.2 percent of benefit payments. Payments for Medicare and Medicaid benefits, including the State Children's Health Insurance Program, are expected to be $359 billion in FY 2001. However, none of those mandatory benefits can be paid without the activities and initiatives funded from this discretionary account.

In FY 2001, HCFA requests a current law discretionary program level of $2,150.7 million. This includes a Program Management appropriation of $2,086.3 million—an increase of $93.0 million, or 4.7 percent, above the FY 2000 appropriation, net of the 0.38 percent rescission—plus collections of $64.4 million from estimated current law user fee receipts.

In addition to $64.4 million in current law user fees, we are proposing a $355 million increase in user fee collections—$224.3 million in new user fees and $130.7 million in existing user fees—through authorizing legislation that makes both the fee collection and spending contingent on approval by the Appropriating Committees. The new user fees include $220 million in Program Management collections. Since this amount is already reflected in HCFA's FY 2001 current law appropriation request of $2,086.3 million, the enactment of these proposals would offset the appropriation, reducing HCFA's request to $1,866.3 million. We are also seeking $4.3 million in new user fees associated with operating the nursing home patient abuse registry and $130.7 million from a proposed increase in the authorization level for Medicare+Choice. These collections are not reflected in the current law appropriation request. In total, HCFA's program level request is $2,285.7 million. Before I discuss the line items or "accounts" that comprise Program Management, I would like to describe HCFA's user fee proposals.

FUNDING THROUGH USER FEES

To find the stable administrative resources necessary to manage our responsibilities effectively without drawing on scarce discretionary budget resources, the Administration is again proposing user fees. Our FY 2001 program level budget request includes $419.4 million in user fees—$355 million in proposed user fees and $64.4 million in current law user fees—that will finance almost 20 percent of our budget request. HCFA is committed to maintaining a balanced Federal budget. At the same time, there is a compelling

need for adequate administrative spending to manage the Medicare, Medicaid, and SCHIP programs effectively.

These user fees will support ongoing Medicare+Choice information campaign activities nationwide, as well as strengthen the effectiveness and efficiency of HCFA's Program Management operations. The new user fee proposals include managed care application and renewal, initial provider certification and provider re-certification, paper claims submission, and submission of duplicate or "unprocessable" claims. The costs of these activities are currently absorbed in HCFA's Program Management budget. We believe that these user fees are sound policy that could affect positive change in the Medicare program. For example, the duplicate and "unprocessable" claims fee will deter providers from submitting these time-consuming, wasteful claims.

In order to facilitate enactment of the user fees, we have proposed authorizing legislation which makes both the fee collection and spending dependent on action by the Appropriations Committees. Since our FY 2001 request reflects our total funding needs, the enacted user fees would offset our appropriation by the amount of the proposal. We are eager to work with this Committee to ensure that HCFA's funding level is sufficient to meet its program responsibilities.

I would now like to discuss briefly the four items or "accounts" that comprise Program Management: Research, Demonstrations and Evaluations; Medicare Contractors; Medicare State Certification; and Federal Administration.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

The FY 2001 Research and Demonstrations request is $55.0 million, a decrease of $6.8 million from the FY 2000 appropriation, net of the 0.38 percent

recission. The request consists of $34.0 million for the continuation of ongoing research activities, including $11.4 million to continue the Medicare Current Beneficiary Survey, the data from which support HCFA researchers in many studies of health care financing delivery mechanisms. The remaining $21.0 million consists of $9.0 million for the implementation of new projects, such as Vulnerable Populations Research which includes the Violence Against Women Initiative, and $12.0 million for activities that support the Balanced Budget Act of 1997 such as demonstrations and evaluations of medical savings accounts and competitive pricing.

MEDICARE CONTRACTORS

Our request for the Medicare contractors continues to emphasize improvements in customer service and claims operations, while investing for future increases in productivity. The FY 2001 Medicare contractor budget request of $1.3 billion reflects an increase of $57.3 million over the FY 2000 appropriation level. This request includes $136 million in proposed user fees that would charge providers $1.00 for submitting paper claims, or duplicate or unprocessable claims. The three key contractor activities are claims processing, beneficiary and provider services, and productivity investments.

In FY 2001, we propose spending $812.5 million for claims processing activities, a slight increase of $2.9 million over the FY 2000 appropriated level. This increase reflects the inclusion of additional funding for a systems security initiative and needed systems maintenance, offset by a slight decrease in estimated claims volumes—from the 925 million estimate in the FY 2000 President's budget request to the 919 million projected for FY 2001. We are asking for $294.2 million for beneficiary and provider services including funds to process appeals, respond to inquiries, educate and train providers, and support the National Medicare Education Program. This request is the same level as

FY 2000 but does not include the $10 million for a one-time long-term care national education campaign included in the FY 2000 appropriation. The FY 2001 request is needed to cover escalating inquiry workloads, the by-product of Medicare+Choice and Medicare Integrity Program activities. The request also allocates $149 million for productivity investments including the redesign of HCFA's existing managed care system; the enhancement of our customer-oriented, toll-free telephone service; the implementation of administrative simplification provisions of the HIPAA, primarily the development of national identifiers for providers and health plans; a new contractor oversight initiative which includes a contractor performance evaluation program, the development and implementation of internal controls, and a new integrated general ledger accounting system; and the continuation of transitions—now that Y2K compliance has been achieved—to one of three standard Medicare claims processing systems. The request also includes $40 million to implement BBA provisions, primarily the collection of encounter data.

MEDICARE STATE CERTIFICATION

The Medicare State certification program ensures that facilities participating in Medicare meet Federal health, safety and program standards. The Medicaid survey and certification counterpart is funded through the grants to States for Medicaid. State survey and certification activities seek to secure quality services for all Medicare and Medicaid beneficiaries. The FY 2001 Medicare State certification budget request is $234.1 million, including $63 million in proposed user fees. The request includes $182.3 million for direct survey activities, $3.1 million over the FY 2000 appropriated level. The FY 2001 request also includes $29.7 million for the Administration's Nursing Home Initiative, an increase of $11.3 million over FY 2000. Lastly, $22.1 million is requested for support contracts, an increase of $15.1 million over FY 2000.

This funding level will provide the necessary resources to keep pace with the continuous growth in the program, while allowing us to continue key provisions of the Nursing Home Initiative. Senator Breaux of the Special Commission on Aging recently complimented HCFA's efforts on this enormous undertaking, citing favorable comments by many consumers and the advocacy community.

The request will support inspections of all facilities seeking to participate in Medicare for the first time, as well as statutorily-mandated re-inspections of all currently participating nursing homes and home health agencies. Also, the request supports inspections of approximately one-third of end-stage renal disease facilities and non-accredited hospitals, up from 15 percent in FY 2000, and 15 percent of all other non-statutorily mandated facilities. Moreover, HCFA will continue to pursue increased program efficiencies and look at ways to optimize our survey process, including development of a budgeting method that will rationalize survey and certification costs.

FEDERAL ADMINISTRATION

The Federal Administration portion of the Program Management account supports the day-to-day operations of HCFA's headquarters, as well as our 10 regional offices nationwide. The FY 2001 request of $495.9 million includes $21.0 million in proposed user fees authorizing the collection of initial registration and annual renewal fees from Medicare+Choice plans. The requested funding level will allow HCFA to enhance program oversight activities and improve the way we relate to our beneficiaries, providers, and other stakeholders. This funding level, an increase of $13.0 million over FY 2000, will pay for 4,353 FTEs, including 100 additional FTEs for Medicare contractor oversight and 20 additional FTEs for activities attributable to the Nursing Home

Initiative. These resources are critical to HCFA's success in strengthening oversight of Federal health facilities and improving oversight of its contractors.

MEDICARE INTEGRITY PROGRAM

Although the Medicare Integrity Program (MIP) is permanently funded through the Hospital Insurance Trust Fund, we have included it in this statement because reducing fraud, waste, and abuse is my top priority for HCFA. The FY 2001 funding level for MIP activities is $680 million, an increase of $50 million above the FY 2000 level.

Following the approach in our *Comprehensive Plan for Program Integrity*, published in FY 1999, we are directing our resources at the most vulnerable areas to maximize our return on investment, to protect scarce taxpayer funds, and ultimately to protect the fiscal integrity of the trust funds. Program integrity activities include medical reviews, both random review and focused pre-payment; provider audits; collaborative efforts with HCFA's partners, such as the OIG Hotline; and the Medicare secondary payer program which seeks to ensure that payment is made by the appropriate primary payer. Last year the Federal Government recovered nearly $500 million as a result of health care prosecutions.

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

Our FY 2001 budget request incorporates HCFA's annual performance plan (APP), as required under GPRA. The plan sets out our specific performance goals for FY 2001 and describes the steps planned and underway to accomplish each goal. We have based our performance measurement approach on two principles: (1) the most important things to measure relate to ensuring that beneficiaries receive the high-quality care they need, and (2) we will pursue measures that are representative of program performance.

This plan is closely linked to the objectives set forth in the Department of Health and Human Services and HCFA Strategic Plans. The APP is also the first annual performance report in which HCFA is reporting on agency performance on its FY 1999 GPRA goals.

Overall, we experienced positive results during our first reporting year. We have met or exceeded expectations with 9 of the 12 goals for which we have complete data. Of the 18 goals in the FY 1999 performance plan, we have six goals for which we do not have complete data. However, we expect to receive data on all six goals in 2000. Although we did not fully achieve three of our goals, we made significant progress and narrowly missed each of the targets.

All of HCFA's performance goals relate to important outcomes, such as improved beneficiary health and satisfaction, sound fiscal management, and maximum use of appropriate technology to improve service, achieve productivity improvements, and minimize cost.

The FY 2001 plan includes new goals relating to diabetic care; program integrity, including Medicaid program integrity; beneficiary education; contractor oversight; survey and certification; and program management. These goals, as well as a number of goals carried over from FY 2000, represent an important step towards our continued efforts to strengthen coordination with States and other partners and reflect our efforts to improve service delivery to all of our beneficiaries.

Since performance targets in the APP are partially a function of the resource levels requested in the budget, they could change based upon final

Congressional appropriations action. We look forward to receiving feedback from Congress on our plan and to working with Congress on achieving our goals.

CONCLUSION

This request—a modest 4.7 percent above the FY 2000 enacted level—builds on the opportunities afforded us by the favorable appropriations we received in both FY 1999 and FY 2000. We are ready to face the challenges of a rapidly changing health care arena given adequate resources. I am confident that this funding level will provide us with the resources and the flexibility needed to improve our business practices while carrying out our responsibilities. At stake are the health care services and other vital programs upon which so many millions of Americans increasingly rely.

Thank you for the opportunity to present HCFA's FY 2001 budget request. I look forward to working with this Committee, and I would be happy to respond to any questions or suggestions that you may have.